Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS392AGC	A. BUILDING _____ B. WING _____	10/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH GROUP CARE 3	4018 E BALTIMORE AVENUE LAS VEGAS, NV 89104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted at your facility on October 21, 2008. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 6 total beds. The facility had the following category classified beds: 6 Category 1 beds. The facility had the following endorsements: Residential facility for persons with mental illnesses. The census at the time of the survey was 5 residents. Five (5) residents files were reviewed. One (1) discharged file was reviewed. Two (2) employee files were reviewed. The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE